UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

BRAND NAME MEDICATION

Patient name:_____Medicaid or SS# _____

Physician Name:_____Contact person_____

Phone#:_____Ext. and options_____Fax_____

Pharmacy_____Pharmacy Phone#:___ _____

Requested Medication_____

All information to be legible, complete and correct or form will be returned

_____

FAX DOCUMENTATION FROM PROGRESS NOTES

CRITERIA:

Details of adverse reaction, allergy or inadequate response

AUTHORIZATION:

One year

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy

7/7/6